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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2024/2025 Update: Survey of Initiatives of Michigan's Public Mental Health System

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Abstract

In November 2024, the Community Mental Health Association of Michigan's (CMHA) Center for Healthcare Integration and Innovation conducted a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs (CMH), the state's public Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system. The following study is a result of the annual survey that the Association has been conducting since 2016. Results showed that more than 546 healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. A total of 27 organizations contributed to the survey to discuss the integration between physical, behavioral health, and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts. The results indicate that most organizations led various health integration efforts simultaneously.

Background

To understand the findings of this study, it is important to reflect on the concept of integrated health. The American Psychological Association describes integrated health as an approach that entails a high level of collaboration and communication between health professionals/organizations. It is done through active communication among different mediums of care to address the biological, psychological, and social needs of the consumer.

The Community Mental Health Services Programs (CMHSP) has historically overseen the overall operations and creation of Michigan's public behavioral healthcare and intellectual/developmental disability services system (BHIDD). Through that responsibility, the public Prepaid Inpatient Health Plans (PIHP) were formed and governed by the CMHSP, the provider networks managed by these two sets of public bodies, and the Michigan Department of Health and Human Services (MDHHS). MDHHS funds this system, Michigan's public mental

health system, with state General Fund dollars and Medicaid funding, the latter provided through a monthly shared risk arrangement with the State of Michigan in the form of capitation payments (per Medicaid-eligible).

The public BHIDD system (CMHSPs, PIHP, and providers) has historically taken a whole-person orientation to service delivery, working to address a range of human needs in addition to behavioral health and intellectual disability needs, as well as a range of social determinants of health. This whole-person orientation is grounded in the person-centered, community-based, and recovery-oriented philosophies guiding the system. Over the past several years, CMHSPs, PIHP, and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical healthcare services. This practice has fulfilled these objectives:

- Increased access for BHIDD consumers to primary care services
- Improved access to BHIDD services to persons seen in primary care settings but without ready access to the full array of BHIDD services
- Improved prevention and intervention to reduce serious physical illnesses
- Improved overall health status of consumers.

Because the CMHSP/PIHP/provider system views the health of the consumer and the broader population as its top priority, the full spectrum of health-related needs of the people served needs to be considered and addressed.

While, anecdotally, the CMHA knew that several, diverse integration efforts were in operation across the state, led by CMHSPs, PIHP, and providers within the CMHSP networks in Michigan, there was no formal cataloging of any such initiatives. In 2016, the initial study conducted by the Community Mental Health Association of Michigan (CMHA) Center for Healthcare Integration and Innovation identified a vast array of integration efforts across the state. The Center for Healthcare Integration and Innovation conducted the second annual study in 2017 to capture a picture of the advancement, breadth, and depth of these initiatives. The current study (2024-2025) aims to update the data collected in the previous years, given the rapid and continual development of these initiatives by Michigan's public mental health system. It also serves as an opportunity to assess the changes in Michigan's healthcare integration efforts.

Methods

In October 2024, an electronic survey was sent consisting of 16 questions assessing the level of healthcare integration efforts. This survey was sent out to all CMHA members' senior leadership, with the objective of gathering information regarding the healthcare integration efforts of Michigan's CMHs, PIHP, and providers. A total of 27 CMHA member organizations filled out the survey, which helped the Association capture diverse organizational settings. The results of the

study are compared to the previous year's study as well to assess the longitudinal changes. The study is cognizant of the fact that the surveys every year have gone through a certain level of modification to capture the integration outcomes appropriately, and members have become more oriented with the therefore, the data cannot be fully compared, but it does give us an idea about the overall trends as shown in Table 1 as part of the Annex on page 6.

Findings & Analysis

The 2024-2025 study resulted in several key findings:

A. The state's CMH, PIHP, and provider system has long recognized that the integration and coordination of healthcare services are key tools to improving the health of persons with BHIDD needs, making services more effective and accessible while working to lower the overall cost of healthcare and related human services to the communities served by these BHIDD systems.
B. The variety of healthcare integration initiatives designed and implemented by the state's CMH, PIHP, and provider system is broad, representing dozens of approaches to fostering integration and coordination of care. The range of healthcare integration approaches is captured in Attachment A on page 7.
C. Safety net behavioral and physical healthcare providers are working together to provide vital services through integrated care models. The current study is not only the first to examine healthcare integration efforts among Michigan's public physical and behavioral healthcare systems but is also the consistent data source related to this subject since 2016. The study found that the CMH, PIHP, and provider systems are involved in state-wide efforts to coordinate and integrate care with federally funded Community Health Centers (FQHCs). These efforts include active referral networks, co-location, care coordination, collaborative treatment planning, data sharing, efforts to identify and address the needs of high/super-utilizers, and joint workforce education and training initiatives. All these areas capture the themes that are required for an efficient integrated healthcare system as established by the definition earlier.
D. Three specific types of integration, with considerable complexity, stood out, in addition to a handful of other notable findings. This 2024-2025 study identified 546 healthcare integration efforts occurring across the state, with the potential for more to come. While Michigan has experience in several health integration methods, there were some that stood out more than others. These three main integration efforts implemented by the public system highlight the system's organizational, clinical, technical, and relational complexity. Those efforts were physical health informed BHIDD services, identification of super-utilizers, and consumer/patient empowerment and access. They are discussed below in detail, with the frequency of responses summarized in Attachment B on page 10.
E. Most organizations have increased their focus on healthcare integration. 20 agencies out of the 27 surveyed indicated that they have increased their focus on integration expansion in

the last five years, demonstrating that it has become a higher priority for CMHSPs. See Attachment B on pages 9-12 for the response summary.

1) Physical Health Informed BHIDD Services: Integrating physical health needs and goals into BHIDD services improves outcomes and proves the most effective approach to caring for people with multiple healthcare needs. This study found 111 total initiatives regarding physical health informed BHIDD services.
    a) Identification of Patients Without a Primary Care Provider: 26 sites (96%) reported processes in place to identify patients without a primary care provider and/or patients who have not engaged a primary care provider in the past year. Having a regular primary care provider (i.e., family physician or nurse practitioner) is crucial for obtaining compressive, continuous, accessible, and timely healthcare. A primary care provider allows for coordination among other parts of the healthcare system. Research suggests patients who have a primary care provider benefit from improved care coordination and chronic disease management. They receive more preventative care, are less likely to use emergency services, and have better health outcomes overall.
    b) Facilitating Communication between BHIDD providers and primary care providers (Fostering Integration): 25 sites (92%) reported efforts aimed at fostering communication efforts between BHIDD sites and primary care providers. These efforts included communication via case managers, support coordinators, care managers, and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination, and improves the quality of care.
    c) Health Screening: 21 sites (78%) reported utilization of health screenings. These screenings consist of items designed to identify risk factors for undiagnosed acute or chronic care issues integrated throughout traditional behavioral health assessments. Untreated chronic disease is a major factor in the increased cost of care for people with behavioral health issues or substance use disorders. The implementation of health screening processes allows providers in primary care and other healthcare settings to assess the severity of health issues and identify the appropriate level of treatment.
2) High/Super-Utilizer Initiatives: A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as public safety, housing support, judiciary, and child welfare. The study found 100 joint efforts between CMHs, PIHP, providers, primary care practices, hospitals, and Medicaid Health Plans to address the needs of this population to effectively utilize healthcare resources.
    a) 17 sites (65%) reported active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access.
    b) 15 sites (57%) reported joint efforts with Medicaid Health Plans to address the needs of high/super-utilizers.

c) 17 sites (65%) reported the use of hands-on complex case/care management for persons with complex needs.
d) 12 sites (46%) reported active use of data (Care Connect 360 or other data analytics) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.
e) 13 sites (50%) reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

3) Consumer/patient empowerment and access: This study identified 74 total efforts to empower consumers regarding their physical health. The most common form of access and empowerment was offering consumers healthy lifestyle education, which 21 sites (84%) participate in. These include WRAP, WHAM, smoking cessation, weight control, and exercise courses. The second most frequent method of consumer access was movement to integrate SAMSHA wellness and recovery principles into BHIDD services, as reported by 14 sites (56%).
4) Barriers to expansion: This study sought to understand what barriers agencies were facing that made it difficult to pursue the above efforts. The most common barrier for respondents was staffing, with 19 sites (76%) indicating this as a prominent barrier. A close second was limited resources, with 17 sites (68%) reporting this barrier.

Other notable findings:

- 11 sites (50%) reported psychiatric consultation, either telephonic, video, or face-to-face provided by BHIDD party to primary care site.
- 10 sites (45%) reported BHIDD staff co-located at hospital emergency departments, or BHIDD staff going to the emergency department as regular protocol to provide crisis screening or inpatient admission screening.
- 16 sites (69%) reported an active and frequent referral network.
- 23 sites (85%) reported receiving Admission, Discharge, and Transfer (ADT) data from hospitals and emergency departments.
- 15 sites (65%) reported providing system navigation guidance to consumers (by BHIDD party or in partnership with a healthcare provider or health plan)
- 18 sites (78%) reported workforce training on healthcare integration and health literacy.
- 10 sites (43%) reported a specific position dedicated to healthcare integration training and/or coordination.
- 19 sites (76%) reported experiencing staffing difficulties as a barrier to healthcare integration.

Conclusion

These findings demonstrate significant gains that continue to be made in Michigan to integrate and coordinate healthcare efforts across BHIDD and physical health systems. Through the integration and coordination of healthcare services, CMHs, PIHP, and providers are working to improve the health of persons with BHIDD needs while controlling the overall cost of their

healthcare. This study identified 546 healthcare integration initiatives led by CMHs, PIHPs, and BHIDD providers across the state of Michigan, of which 147 were those involving physical health informed BHIDD services, efforts to address the needs of the high/super-utilizer population, and consumer/patient empowerment and access.

Additionally, CMHs, PIHPs, and BIHDD providers are increasing their efforts regarding healthcare integration. However, there continue to be barriers on a state and workforce level that make it difficult to both facilitate and maintain healthcare integration. These include but are not limited to staffing and information sharing restrictions.

As this series of studies represents the first of its kind to catalog the healthcare integration efforts of the state of Michigan's CMH, PIHP, and provider network, the study will continue to be replicated in the future to track the emergence of new efforts and the changes in the integration services identified in this study.

Annex

Table 1: Healthcare Integration Trends from 2016 to 2025

Year	**Number of Respondents**	**Integration Outcomes**
2016-2017	32	751
2017-2018	38	572
2018-2019	35	663
2019-2020	30	626
2020-2021	25	626
2021-2022	20	451
2022-2023	40	789
2023-2024	36	785
2024-2025	27	546

Attachment A

- **Active referral network**
  - Formal referral agreements between BHIDD party and primary care provider
  - System navigation guidance to consumers (by BHIDD party or in partnership with a healthcare provider or health plan)
  - Active and frequent referral relationship
- **Co-location related efforts**
  - BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)
  - Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)
  - BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as a regular protocol to provide crisis screening or inpatient admission pre-screening
  - Psychiatric consultation, telephonic, video, or face-to-face provided by BHIDD party to primary care site
  - Pharmacy co-located in BHIDD site
  - Physical health laboratory or lab pick-up at BHIDD site
  - Co-funded positions
  - Loaning positions from or to BHIDD party
  - Co-location efforts involve a Community Health Center (FQHC)
- **Physical health informed BHIDD services**
  - Health screening, including identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment
  - Identification of patients without a primary care provider and/or who have not engaged primary care provider in the past year and active referral to such care
  - Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator care manager, nurse care manager, or similar intensive coordination)
  - Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health
  - BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical health care needs
- **Services/supports/treatment plan and Electronic Health Record (EHR)**
  - Single care plan reflecting BHIDD services and supports and physical health treatment

- Shared or linked BHIDD and primary care electronic health records o Admission, Discharge, and Transfer (ADT) data by hospitals and emergency departments with BHIDD party
- Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment
- Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation
- Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)

- **High/super-utilizers/Complex case/care management**
  - Active use of data (Care Connect 360 or other data analytics) to identify high/ super utilizers at the point of access.
  - Active use of data (Care Connect 360) to provide outreach to high/super utilizers who have not accessed the BHIDD system of care.
  - Joint effort with primary care practices to address the needs of high/super utilizers of healthcare resources
  - Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources
  - Joint effort with Medicaid Health Plans, to address the needs of high/super utilizers of health care resources
  - Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care resources
  - Use of hands-on complex case/care management to persons with complex needs
- **Workforce education and training**
  - Joint educational and networking efforts for BHIDD providers and primary care providers
  - BHIDD workforce trained on healthcare integration and health literacy o BHIDD party provides/facilitates training for primary care workforce on BHIDD issues
  - Community Health Centers (FQHCs) are included in training and education efforts
- **Consumer/patient empowerment and access**
  - Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses
  - Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site o Movement to integrate SAMSHA wellness and recovery principles into BHIDD services

    - Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff reducing time on site for consumers
    - Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and enhance access to services
    - Do you have any existing integration partnerships with FQHC?
- **Focus on healthcare integration expansion in the last 5 years**
    - Healthcare integration expansion focus has increased
    - Healthcare integration expansion focus has stayed the same
    - Healthcare integration expansion focus has decreased
- **Barriers to healthcare integration**
    - Limited resources
    - Financial stability
    - Lack of standardization of care technology
    - Conflict with providers
    - Staffing
    - Information sharing restrictions
    - State and federal policy
    - Operational differences in physical vs. mental health treatment

Attachment B

- **Active Referral Network**

Formal referral agreements between BHIDD party and primary care provider	47.83%	11
System navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)	65.22%	15
Active and frequent referral relationship	69.57%	16

- **Co-location related efforts**

BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)	31.82%	7
Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)	54.55%	12
BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as a regular protocol to provide crisis screening or inpatient admission pre-screening	45.45%	10
Psychiatric consultation, telephonic, video, or face-to-face provided by BHIDD party to primary care site	50.00%	11
Pharmacy co-located in BHIDD site	45.45%	10
Physical health laboratory or lab pick-up at BHIDD site	31.82%	7
Co-funded positions	18.18%	4
Loaning positions from or to BHIDD party	4.55%	1
Co-location efforts involve a Community Health Center (FQHC)	40.91%	9
BHIDD providers operate own FQHC	0.00%	0
BHIDD providers operate own non-FQHC primary care provider	4.55%	1

- **Physical health informed BHIDD services**

Health screening, including identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment	77.78%	21
Identification of patients without a primary care provider and/or who have not engaged primary care provider in the past year and active referral to such care	96.30%	26
Actively facilitated communication between BHIDD provider and primary care providers (via casemanager, supports coordinator care manager, nurse caremanager, or similar intensive coordination)	92.59%	25
Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health	66.67%	18
BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical health care needs	59.26%	16
BHIDD providers operate own FQHCs for coordination of physical and mental health care	7.41%	2
BHIDD providers operate own non-FQHC primary care practice for coordination of physical and mental health care	11.11%	3

- **Services/supports/treatment plan and Electronic Health Record (EHR)**

Single care plan reflecting BHIDD services and supports and physical health treatment	44.44%	12
Shared or linked BHIDD and primary care electronic health records	40.74%	11
Admission, Discharge, and Transfer (ADT) data by hospitals and emergency departments with BHIDD party	85.19%	23
Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment	29.63%	8
Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation)	62.96%	17
Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)	44.44%	12

- **High/super-utilizers/Complex case/care management**

Active use of data (Care Connect 360 or other data analytics) to identify high/ super utilizers at the point of access.	65.38%	17
Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.	46.15%	12
Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources	50.00%	13
Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources	46.15%	12
Joint effort with Medicaid Health Plans, to address the needs of high/super-utilizers of health care resources	57.69%	15
Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care resources	53.85%	14
Use of hands-on complex case/care management to persons with complex needs	65.38%	17

- **Workforce education and training**

Joint educational and networking efforts for BHIDD providers and primary care providers	39.13%	9
BHIDD workforce trained on healthcare integration and health literacy	78.26%	18
BHIDD party provides/facilitates training for primary care workforce on BHIDD issues	30.43%	7
Community Health Centers (FQHCs) are included in training and education efforts	21.74%	5
Specific position dedicated to healthcare integration training and/or coordination	43.48%	10

- **Consumer/patient empowerment and access**

Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses	84.00%	21
Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site	52.00%	13
Movement to integrate SAMSHA wellness and recovery principles into BHIDD services	56.00%	14
Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff reducing time on site for consumers	52.00%	13
Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and enhance access to services	52.00%	13

- **Has your organization's focus on healthcare integration changed in the last five years?**

Yes, our focus on expansion has increased.	77.78%	21
No, our focus on expansion has stayed the same.	22.22%	6
Yes, our focus on expansion has decreased.	0.00%	0

- **What barriers to healthcare integration is your organization experiencing?**

None of the above	0.00%	0
Limited resources	68.00%	17
Financial sustainability	60.00%	15
Lack of standardization of care technology	40.00%	10
Conflict with providers	8.00%	2
Staffing	76.00%	19
Information sharing restrictions	48.00%	12
State and federal policy	12.00%	3
Operational differences in physical vs. mental health treatment	44.00%	11

The Center for Healthcare Integration and Innovation (CHI^2) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.